



OBGYN FAMILY & SOCIAL HISTORY

Please check all other Premier locations where you are also a patient.
 St. B
 Richview
 Governor's Sq
 Eye Center
 ENT
 Imaging

Appointment Date: \_\_\_\_\_

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Why are you seeing the doctor today: \_\_\_\_\_

Employed:  Yes  No Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Job Hazards: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widow

Tobacco Use:  Yes  No  Previous Smoker. If Yes, have you tried to quit:  Yes  No. Other smokers in home:  Yes  No

Alcohol Use:  Yes  No  Previous Use. If Yes, how much: \_\_\_\_\_ and how often: \_\_\_\_\_

Caffeine Intake:  Yes  No. If Yes, how much: \_\_\_\_\_ and how often: \_\_\_\_\_

Lifestyle: How physically active are you:  Daily Exercise  3 times/week  Once in awhile  Never

Your Current Form of Birth Control/Contraceptives:

- Patch  Ring  Condom  Depo Provera  Pills  Tubal
 IUD date inserted: \_\_\_\_\_  Diaphragm  Partner has Vasectomy  NONE
 Other: \_\_\_\_\_

Other Current Medications:

Table with 4 columns: Name of Drug, Dose Amount, Taken How Often, Date Started

Menstrual History:

Age of First period: \_\_\_\_\_
Length of bleeding (days): \_\_\_\_\_ First day of last period: \_\_\_/\_\_\_/\_\_\_
# of days from the first day of bleeding until the next first day: \_\_\_\_\_
Describe Bleeding:  light  normal  heavy
 regular  Irregular
Describe Menstrual Pain:  None  Normal  Severe
 Received Gardasil Vaccine Year: \_\_\_\_\_
Age at Menopause: \_\_\_\_\_ Use hormones:  Yes How Long: \_\_\_\_\_  No
Year of Last Bone Density Test: \_\_\_\_\_ Last Mammogram: \_\_\_\_\_ Last Colonoscopy: \_\_\_\_\_

Name of Your Pharmacy: \_\_\_\_\_
Pharmacy's Address: \_\_\_\_\_

STD Screening: We recommend STD Screening for sexual active women every year until age 25.
Do you want to be tested for STDs:  Yes, I agree to be tested  No, I decline testing

Drug Allergies: Drug/Medication Allergies:  Yes  No If Yes, please list drug names and reactions:

Other Allergies:  Latex  Surgical soaps  Surgical tape  Other skin contact allergy: \_\_\_\_\_
List your reactions: \_\_\_\_\_

Obstetric History: Currently Pregnant:  Yes  No  Possibly

Pregnancy History:

Summary table with columns: # of Pregnancies, # Term Births, # of Preterm Births, # C-Sec Births, # Vaginal Births, # Living Children, # Ectopic Pregnancies, # of Miscarriages, # of Abortions

Past Pregnancies:

Detailed table with columns: Sex M/F, Month/Yr, Gestational Age/Weeks, Birth Weight, Labor Length, Type of Delivery, Place of Delivery, Doctor, Comments/Complications

### Your Health History

- Abnormal PAP or History Of  Yes  No
- Blood Transfusion/ History Of  Yes  No
- Blood Clot, DVT, PE/History Of  Yes  No
- Breast Cancer  Yes  No
- Breast Disease  Yes  No
- Bruising/Bleeding Disorder  Yes  No
- Cervical Cancer  Yes  No
- DES Exposure  Yes  No
- Diabetes  Yes  No
- Diabetes During Pregnancy  Yes  No
- Endometriosis  Yes  No
- Hepatitis Type: \_\_\_\_\_  Yes  No
- History of Genital Herpes  Yes  No
- High Cholesterol  Yes  No
- Infertility  Yes  No
- Ovarian Cancer  Yes  No
- High Blood Pressure  Yes  No
- Rheumatic Fever  Yes  No
- Sexually Transmitted Disease  Yes  No
- Stroke (CVA)  Yes  No

**Surgical History:**

- Augmentation (Breast)  Yes  No
- Tubal  Yes  No
- Breast Biopsy  Yes  No
- Cesarean Section  Yes  No
- D and C  Yes  No
- Gallbladder Removed  Yes  No
- Myomectomy  Yes  No
- Reduction (Breast)  Yes  No
- Hysterectomy  Yes  No
- Ovaries Removed  Yes  No
- Bladder Surgery  Yes  No
- Appendectomy  Yes  No
- Endometrial Ablation  Yes  No
- LEEP  Yes  No
- Cryo  Yes  No

Other surgeries you have had:

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OTHER Diseases/Medical Conditions: \_\_\_\_\_

### How Are You Today

**Pos/Neg**

**Digestive Tract**

- Yes  No  
 Yes  No

- Have you had an abdominal pain recently  
 Have you found blood in your stools recently

**Genital/Urinary Tract**

- Yes  No  
 Yes  No  
 Yes  No  
 Yes  No  
 Yes  No  
 Yes  No  
 Yes  No  
 Yes  No  
 Yes  No  
 Yes  No  
 Yes  No  
 Yes  No  
 Yes  No

- Have you experienced the lack of periods recently (amenorrhea)  
 Have you experienced painful periods recently (dysmenorrhea)  
 Have you experienced difficult or painful intercourse recently (dyspareunia)  
 Have you experienced difficult and/or painful urination recently (dysuria)  
 Have you had problems with frequent urination recently  
 Have you experienced blood in your urine recently (hematuria)  
 Have you experience heavy or excessive bleeding during your periods/menstruation recently (menorrhagia)  
 Have you had problems with intense urges to urinate recently  
 Have you had problems with being unable to hold your urine before reaching a bathroom (urinary incontinence)  
 Have you had problems with vaginal discharge recently  
 Have you had problems with vaginal itching recently

**Skin/Breast**

- Yes  No  
 Yes  No  
 Yes  No  
 Yes  No

- Have you experienced any discharge from your breast(s) recently  
 Have you found any lumps in your breast(s) recently  
 Have you experienced any pain in your breast(s) recently  
 Do you have problems with abnormal hair growth (hirsutism)

**Family History: Please let us know about your family's (Blood Relatives Only) health. Please answer these questions as completely as you can.**

Parents, Siblings, Children	Any family members	List Family Member	Age of Onset	Age of Death
Blood Clotting Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Breast Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No			
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Colon Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No			
Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Ovarian Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No			
High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No				
High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No				
Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No				
Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No				

Other: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_